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360-degree appraisal: a simple pragmatic solution

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Abstract

Purpose – The purpose of this paper is to describe the use of a web-based process of 360-degree appraisal in teaching and district general hospital settings.

Design/methodology/approach – A total of 554 consultants were appraised by both peers and patients with over 16,000 replies using a web-based questionnaire and patient survey.

Findings – Overall results were satisfactory, although in the areas of communication, team working and leadership there was evidence of room for improvement in 1 in 12 doctors especially in the fields of psychiatry, medicine and A&E. Those being appraised found the process positive.

Originality/value – The study demonstrates a simple pragmatic solution to consultant 360-degree appraisal.

Keywords 360 degree feedback, Performance appraisal, Consultants, Worldwide web

Paper type Research paper

Introduction

Assessment of how a doctor relates to patients and others with whom they work is a crucial aspect of annual appraisal and in all probability revalidation. This is important for two reasons. First, assurance that problems in interpersonal relationships do not exist for an individual and second, to reassure an individual practitioner that they are doing a good job in a world where criticism is increasingly frequent. 360-degree appraisal is well accepted in many work places as a means of achieving this end and is growing in acceptance in medicine. A means whereby such an assessment can be undertaken with minimum intrusion into the working practice of the individual doctor, while producing meaningful and reproducible data has not been achieved. In this paper we present our findings from a web based system based on the principles of the GMC's document, *Good Medical Practice in University Teaching and District General Hospitals*.

Methods

The two questionnaires used were based on the work of Ramsey (Ramsey *et al.*, 1993) and developed at Guy's and St Thomas NHS Foundation Trust (Mason *et al.*, 2001;

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Mason *et al.*, 2003). The questions are shown in the Appendix. The responses were divided into four categories – poor, fair, good or very good, avoiding a "middle – no committal" answer together with a box for unable to comment. The process was run centrally by a commercial partner 360 clinical who undertook the collation and production of the report and ensured full confidentiality of the replies.

For the peer questionnaire, each consultant was contacted by e-mail and asked to give 15 names and e-mail addresses for assessors. These had to include consultants with whom they worked, trainees, nurses and other allied health care professionals. This list was approved by their designated facilitator. After approval, these assessors were contacted by email to complete the web based questionnaire for the consultant by "ticking the replies". Time to complete was less than two minutes and there was space for comments.

Patient questionnaires were usually completed in outpatient clinic or where appropriate, the ward. A total of 30 questionnaires were given to consecutive patients by the clinic/ward nurse after the consultation and completed replies sent direct to 360 Clinical. In the case of paediatrics, the questionnaires were completed by the parent/guardian.

At the bottom of each form was a free text box for comments.

When all questionnaires (a minimum of ten returns for peers and 20 for patients) were obtained a comprehensive report was produced and sent to the facilitator to give to the individual consultant and discuss the results. It was possible to produce comparator scores between consultants in an individual hospital and/or specialty.

Results

A total of 554 consultants have undergone 360-degree appraisal by this method with over 16,000 replies. There has been to date only one refusal by a consultant to participate – "a matter of principle, a waste on money". There has been no refusal by individuals asked to score and their response has been universally favourable and constructive, as has the response been from patients.

The average score for the seven peer and five patient questions by specialty is shown in Table I. The average was between three and four (good and very good) for all specialties. There was no difference between teaching and district general hospitals.

This procedure does not have a pass/fail mark but three or more poor/fairs for a question should provoke discussion.

The results for peer questionnaires are shown in Table II. It is apparent that there are rarely problems in clinical skills, availability, compassion, responsibility and

Table I.
Mean score for all seven questions by specialty (max. four)

	Peer	Patient
A&E	3.71	3.75
Psychiatry	3.66	3.47
Medicine (inc. sub-specialties)	3.68	3.83
Surgery (inc. sub-specialties)	3.71	3.83
Anaesthetics	3.78	3.82
O&G	3.74	3.79
Paediatrics (inc. sub-specialties)	3.74	3.87
Radiology	3.38	3.73

teaching. In contrast 1 in 12 doctors appear to have problems with team working and leadership and management (Table III). When broken down by specialty, problems with these two issues seem to be greater in psychiatry, A&E, medicine and its sub-specialties and radiology.

There was no difference for specialty regarding the number of poor/fair between teaching and district general hospitals.

With regard to patient questionnaires, no particular question appeared to score worse with regard to poor/fair scores (Table IV). It is apparent that almost 1 in 12 doctors could, however, improve communication skills especially with regard to treatment decisions and continued information and feedback. When broken down by specialty, psychiatry was the only one to score lower than other groups (Table V). Again there was no difference between teaching and district general hospital.

Free text was used in approximately half of cases and was generally supportive.

Percentage of all doctors who may have a problem with:	Percent
Clinical skills	1.62
Availability	3.79
Compassion to patients	2.89
Accepting responsibility for their actions	2.58
Team working	8.30
Teaching	1.8
Leadership and management	7.76

Table II. Consultants receiving three or more poor/fair scores for individual questions in Peer questionnaire

	Team working (percent)	Management leadership (percent)
A&E	11.8	17.6
Psychiatry	14.5	19
Medicine (inc. sub-specialties)	12.1	12
Surgery (inc. sub-specialties)	7.9	7.7
Anaesthetics	4.8	5.3
O&G	7.3	2.4
Paediatrics (inc. sub-specialties)	5.9	3.7
Radiology	15	10

Table III. Percentage of doctors by specialty with three or more scores of poor/fair for team working and management/leadership

Percentage of all doctors who may have a problem with:	Percent
Q1 Respect	5.4
Q2 Your perspective	7.8
Q3 Clarity and simplicity	5.9
Q4 Involvement in treatment decisions	8.1
Q5 Information in hospital journey	8.6

Table IV. Consultants receiving three or more poor/fair scores for individual questions in Patient questionnaire

Discussion

When considering the results of 360-degree appraisal it is important to realise the limitations of the process. It is not a process that should reveal problems in individuals that were not already known. Nor should it be used as a disciplinary process or a means of determining promotion or whether an individual receives a Clinical Excellence Award. It is a means to introduce reflection on practice and change on the basis of evidence and not hearsay. It is for this reason that the report is given to the facilitator to take to and discuss with the appraisee.

We feel the use of statistics detracts from the aim of 360-degree appraisal as this is a process of education not research. The use of numbers is to encourage change in behaviour and not competition and chasing the $p < 0.05$. This approach has been vital in gaining broad acceptance for the process. If individuals felt there would be statistical analysis of their scores there would be reluctance to participate. The comparison between groups is again to focus attention. If the differences were not significant it could lead to complacency re modification of behaviour.

To get accurate responses, it is crucial to ensure anonymity. This is achieved by making the process web based with secure communication and collation by an outside body – in this case 360 clinical.

The fact that the vast majority of doctors score well especially with regard to quality of care, availability, responsibility, compassion and teaching is reassuring both to the employer and individual and is in agreement with the broader perception of the profession in the public at large. The issues regarding team working, management and leadership and communication with patients reflect the changing work patterns. No longer do consultants behave as individuals but as members of multidisciplinary teams. Patients are far more involved in decisions regarding their illness. This study demonstrates that more work needs to be undertaken to strengthen these new skills. In individual cases where there were three or more poor/fair scores, feedback to the individual was in virtually all cases positive in delivery and reception.

How often should the procedure be repeated and does it justify the cost? Consensus that there should be one or more 360 in every revalidation cycle, i.e. every three years for consultants with satisfactory results would seem a sensible compromise. For "problem individuals", repeat assessment after remedial action is easy. The cost of £97 per consultant every three years is inexpensive when balanced against the positive effect on the consultant morale.

Table V.
Percentage by specialty of doctors with three or more scores of poor/fair for each question

	Q1 (%)	Q2 (%)	Q3 (%)	Q4 (%)	Q5 (%)
A&E	0	0	11	11	0
Psychiatry	11	14.8	14.8	18.5	25.9
Medicine (inc. sub-specialties)	4.7	7.1	4.7	4.7	7.1
Surgery (inc. SUB-specialties)	4	8	8	8	4
Anaesthetics	0	0	0	0	0
O&G	2.7	10.8	2.7	5.4	5.4
Paediatrics (inc. sub-specialties)	3.9	3.9	3.9	5.9	9.8
Radiology	0	12.5	0	12.5	6.3

Should an individual consultant choose who assesses them? Evidence from the USA (Ramsey *et al.*, 1993) and our previous work (Mason *et al.*, 2001; Mason *et al.*, 2003) suggests giving the individual some ownership improves substantially the acceptance of the process and if confidentiality is ensured assessors will give honest answers. Similarly, a consultant knowing they are being assessed particularly in the outpatient clinic, might change behaviour. This is a good thing and when allied to good results should encourage, in all but the most recalcitrant, good practice.

Are the questions too generalised and should there be specialty based questions? In this exercise from the beginning we set out to produce a simple generic questionnaire suitable for all doctors and fulfilling the requirements of Good Medical Practice.

Our initial work (Mason *et al.*, 2001) based on Ramsey started with ten questions, which were reduced to five as a result of positive feedback for the shorted questionnaire from both peers and patients (Mason *et al.*, 2003). It has increased to include questions on teaching and leadership and management. It is possible in a web-based system to add specialty-based questions without affecting the main question body as long as questionnaire fatigue is not introduced.

In conclusion we feel we have developed a pragmatic, successful method of 360-degree appraisal for doctors which should provide suitable data for revalidation, appraisal and the reassurance to doctors and patients that the quality of care they give and receive is if a high order. By making the system web based and paper free other than patient questionnaires, the system is easy to administer with minimal intrusion while maintaining confidentiality to all concerned and enabling comparison to be made between specialties, institutions and regions.

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Appendix

Questionnaire to peers – to be marked poor, fair, good, very good or cannot answer:

Q1 Can manage complex clinical problems?

Q2 Is available to give help and advice when needed?

Q3 Shows compassion to patients and relatives?

Q4 Accepts responsibility for actions and is honest with results?

Q5 Works well as a team member?

Q6 Ensures that students and junior colleagues receive appropriate educational supervision?

Q7 Is an effective manager, defining what needs to be done and achieving it through appropriate people?

Questionnaire to patients – the doctor:

Q1 Treats you with respect and consideration.

Q2 Encourages you to tell your story and ask questions.

Q3 Uses words you can understand.

Q4 Discusses treatment options with you and your family.

Q5 Continues to keep you fully informed throughout your illness and treatment.

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